CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Community Alternatives

(Amendment)

907 KAR 1:030. Home health agency services.

RELATES TO: KRS 205.502, 42 C.F.R. 440.70, 447.325, 484.4, 45 C.F.R. 164.316, 42 U.S.C. 1396a-d

STATUTORY AUTHORITY: KRS 194A.030(2)[(3)], 194A.050(1), 205.520(3)[, EO 2004-726]

NECESSITY, FUNCTION, AND CONFORMITY: [EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[for the provision of Medical Assistance to Kentucky's indigent citizenry]. This administrative regulation establishes the coverage provisions and requirements relating to Medicaid Program home health care services[for which payment shall be made by the Medicaid Program in behalf of both the categorically needy and the medically needy].

Section 1. Definitions. (1) "Department" means the Department for Medicaid Services

or its designee.

(2) “Electronic signature is defined by KRS 369.102(8).

(3) “Enrollee” means a recipient who is enrolled with a managed care organization.

(4) “Federal financial participation” is defined by 42 C.F.R. 400.203.

(5) "Home health agency" or "HHA" means:

(a) An agency defined pursuant to 42 C.F.R. 440.70(d)l and

(b) A Medicare and Medicaid-certified agency licensed in accordance with 902 KAR 20:081.

(6)[~~(3)~~] "Home health aide" means a person who meets the home health aide requirements established in 902 KAR 20:081.

(7)[~~(4)~~] "Licensed practical nurse" or "LPN" means a person who is:

(a) Licensed in accordance with KRS 314.051; and

(b) Under the supervision of a registered nurse.

(8) “Managed care organization” means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(9)[~~(5)~~] "Medical social worker" means a person who meets the medical social worker requirements as established in 902 KAR 20:081.

(10)[~~(6)~~] "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(11)[~~(7)~~] "Nursing service" means the delivery of medication, or treatment by a registered nurse or a licensed practical nurse supervised by a registered nurse, consistent with KRS Chapter 314 scope of practice provisions and the Kentucky Board of Nursing

scope of practice determination guidelines.

(12)[~~(8)~~] "Occupational therapist" is defined by KRS 319A.010(3)[~~means a person who meets the occupational therapist requirements established in 902 KAR 20:081~~].

(13) “Occupational therapy assistant” is defined by KRS 319A.010(4).

(14)[~~(9)~~] "Physical therapist" is defined by KRS 327.010(2)[~~means a person who meets the physical therapist requirements established in 902 KAR 20:081~~].

(15) “Physical therapy assistant” means a skilled health care worker who:

(a) Is certified by the Kentucky Board of Physical Therapy; and

(b) Performs physical therapy services and related duties as assigned by the supervising physical therapist.

(16)[~~(10)~~] "Place of residence" means, excluding a hospital or nursing facility, the location at which a recipient resides.

(17)[~~(11)~~] "Plan of care" means a written plan which shall:

(a) Stipulate the type, nature, frequency and duration of a service; and

(b) Be reviewed and signed by a physician and HHA staff person at least every sixty (60) days.

(18) “Provider” is defined by KRS 205.8451(7).

(19)[~~(12)~~] "Qualified medical social worker" means a person who meets the qualified medical social worker requirements as established in 902 KAR 20:081.

(20)[~~(13)~~] "Qualified social work assistant" means a social work assistant as defined in 42 CFR 484.4.

(21) “Recipient” is defined by KRS 205.8451(9).

(22)[~~(14)~~] "Registered nurse" or "RN" is defined by KRS 314.011(5)[~~means a person~~

~~licensed in accordance with KRS 314.041~~].

(23)[~~(15)~~] "Speech-language pathologist" is defined by KRS 334A.020(3)[~~means a person who meets the speech pathologist requirements established in 902 KAR 20:081~~].

(24) “Speech-language pathology assistant” is defined by KRS 334A.020(8).

Section 2. Conditions of Participation. (1) In order to provide home health services, a provider shall:

(a) Be an HHA; and

(b) Comply with:

(a) 907 KAR 1:671;

(b)[,] 907 KAR 1:672;

(c)[~~, and~~] 907 KAR 1:673;

(d) All applicable state and federal laws; and

(e)[~~(c) Comply with~~] The Home Health Services Manual.

(2)(a) A home health provider shall maintain a medical record for each recipient for whom services are provided.

(b) A medical record shall:

1. Document each service provided to the recipient including the date of the service and the signature of the individual who provided the service

[~~(a) Substantiate the services billed to the department and be signed and dated by HHA staff~~];

2.[~~(b)~~] Contain a copy of the plan of care;

3.[~~(c)~~] Document verbal orders from the physician, if applicable;

4. Except as established in paragraph (d) of this subsection, be retained for a minimum of five (5) years from the date a covered service is provided or until any audit dispute or issue is resolved beyond five (5) years

5.[~~, except in the case of a minor, whose records shall be retained for three (3) years after the recipient reaches the age of majority under state law, whichever is longest;~~

~~(e)~~] Be kept in an organized central file within the HHA; and

6.[~~(f)~~] Be made available to the department upon request.

(c) The individual who provided a service shall date and sign the health record on the date that the individual provided the service.

(d)1. If the Secretary of the United States Department of Health and Human Services requires a longer document retention period than the period referenced in paragraph (a) of this section, pursuant to 42 CFR 431.17, the period established by the secretary shall be the required period.

2. In the case of a recipient who is a minor, the recipient's medical record shall be retained for three (3) years after the recipient reaches the age of majority under state law or the length established in paragraph (b)4 of this subsection or subparagraph 1 of this paragraph, whichever is longest.

(3) A provider shall comply with 45 Chapter 164.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

Section 3. Covered Services. (1) A home health service shall be:

(a) [~~Effective November 15, 2001, be~~] Prior authorized by the department to ensure that the service or modification of the service is medically necessary and adequate for the needs of the recipient;

(b) [~~Be~~] Provided pursuant to a plan of care; and

(c) [~~Be~~] Provided in a recipient's place of residence.

(2) The following services provided to a recipient by a home health provider[~~,~~] who meets the requirements in Section 2 of this administrative regulation[~~,~~] shall be covered by the department:

(a) A nursing service which shall:

1. Include part-time or intermittent nursing services;

2. If provided daily, be limited to thirty (30) days unless additional days are prior authorized by the department;

(b) A therapy service which shall:

1. Include physical therapy services provided by a physical therapist or a [~~qualified~~] physical therapy[~~therapist~~] assistant [~~as defined in 42 CFR 484.4~~] who is under the supervision of a [~~qualified~~] physical therapist;

2. Include occupational therapy services provided by an occupational therapist or an[~~a qualified~~] occupational therapy assistant [~~as defined in 42 CFR 484.4~~] who is under the supervision of an[~~a qualified~~] occupational therapist;

3. Include speech pathology services[~~therapy~~] provided by [~~or under the supervision of~~] a speech-language pathologist or a speech-language pathology assistant who is un-

der the supervision of a speech-language pathologist;

4. Be provided pursuant to a plan of treatment which shall be developed by the appropriate [~~qualified~~] therapist and physician; and

5. Be provided in accordance with 907 KAR 1:023; and

6. Comply with the:

a. Physical therapy service[~~, occupational therapy, and speech therapy~~] requirements established in the:

(i) [~~"~~]Technical Criteria for Reviewing Ancillary Services for Adults if the therapy service is a physical therapy service provided to an adult;[~~, February 2000 Edition"~~] or

(ii) [~~"~~]Technical Criteria for Reviewing Ancillary Services for Pediatrics if the therapy service is a physical therapy service provided to a child[~~, April 2000 Edition"~~];

b. Occupational therapy requirements established in the:

(i) Technical Criteria for Review Ancillary Services for Adults if the therapy service is an occupational therapy service provided to an adult; or

(ii) Technical Criteria for Review Ancillary Services for Pediatrics if the therapy service is an occupational therapy service provided to a child; or

c. Speech pathology service requirements established in the:

(i) Technical Criteria for Review Ancillary Services for Adults if the service is a speech pathology service provided to an adult; or

(ii) Technical Criteria for Review Ancillary Services for Pediatrics if the service is a speech pathology service provided to a child;

(c) A home health aide service which shall:

1. Include the performance of simple procedures as an extension of therapy ser-

vices, personal care, range of motion exercises and ambulation, assistance with medications that are ordinarily self-administered, reporting a change in the recipient's condition and needs, incidental household services which are essential to the recipient's health care at home when provided in the course of a regular visit, and completing appropriate records;

2. Be provided by a home health aide who is supervised at least every fourteen (14) days[~~two (2) weeks~~] by:

a. An RN;

b. A physical therapist, for any physical therapy services that are provided by the home health aide;

c. An occupational therapist, for any occupational therapy services that are provided by the home health aide; or

d. A speech-language pathologist [~~therapist~~], for any speech pathology[~~therapy~~] services that are provided by the home health aide; and

3. Be a service that the recipient is either physically or mentally unable to perform;

(d) A medical social service which shall:

1. Be provided by a qualified medical social worker or qualified social work assistant; and

2. Be provided in conjunction with at least one (1) other service listed in this section;

(e) A disposable medical supply which shall:

1. Include the following:

a. An adapter;

b. An applicator;

c. Drainage supplies;

d. Dressing supplies;

e. Catheter, ileostomy or ureostomy supplies;

f. Colostomy supplies;

g. A detection reagent for other than sugar or ketone;

h. Except for the limitations contained in Section 4(5) of this administrative regulation, diapers, underpads or incontinent pants;

i. An egg crate mattress;

j. An enema or elimination supplies including a fleet enema or dulcolax suppository;

k. Gastrostomy supplies;

l. Gloves;

m. Inhalation therapy supplies;

n. Irrigation solutions;

o. IV therapy supplies;

p. Lambs wool or a synthetic pad;

q. A lotion, powder or cream for an invalid or bedfast recipient;

r. A nipple if designed for cleft palate;

s. Inexpensive occupational therapy supplies which may include a plastic utensil holder or a long arm reacher;

t. Suction supplies;

u. Support supplies which may include antiembolism stockings, support vest, support gauntlet, or support glove;

v. A syringe or needle (excluding an insulin syringe for a diabetic);

w. Tracheostomy supplies; or

x. Tubing; and

2. If provided to a recipient who is not in need of a home health visit, be required to maintain him in his place of residence. A physician shall certify the medical necessity of a disposable medical supply by completing and signing a MAP 248 form; and

(f) An enteral nutritional product which shall:

1. Be ingested orally or delivered by tube into the gastrointestinal tract; and

2. Provide for the total or supplemental nutrition of a recipient.

Section 4. Limitations and Exclusions from Coverage. (1) A domestic or housekeeping service which is unrelated to the health care of a recipient shall not be covered.

(2) A medical social service shall not be covered unless provided in conjunction with another service pursuant to Section 3 of this administrative regulation.

(3) Supplies for personal hygiene shall not be covered.[;]

(4) Drugs shall not be covered.

(5) Disposable diapers shall not be covered for a recipient age three (3) years and under regardless of the recipient's medical condition.

(6) Except for the first week following a home delivery, a newborn or postpartum service without the presence of a medical complication shall not be covered.

(7) A recipient who has elected to receive hospice care shall not be eligible to receive coverage under the home health program.

(8)(a) There shall be an annual limit of twenty (20):

1. Occupational therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection;

2. Physical therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection; and

3. Speech therapy service visits per recipient per calendar year except as established in paragraph (b) of this subsection.

(b) The limits established in paragraph (a) of this subsection may be exceeded if services in excess of the limits are determined to be medically necessary by the:

1. Department if the recipient is not enrolled with a managed care organization; or

2. Managed care organization in which the enrollee is enrolled if the recipient is an enrollee.

(c) Prior authorization by the department shall be required for each visit that exceeds the limit established in paragraph (a) of this subsection for a recipient who is not enrolled with a managed care organization.

Section 5. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.

(2) For example, if a recipient is receiving a speech pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for a speech pathology service provided to the same recipient during the same time period via the home health services program.

Section 6. Third Party Liability. A provider shall comply with KRS 205.622.

Section 7. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his responsibility in allowing the use of the electronic signature; and

(c) Provide the department with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature immediately upon request.

Section 8. Auditing Authority. (1) The department shall have the authority to audit any claim or medical record or documentation associated with any claim or medical record.

Section 9. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 10.[~~5.~~] Appeal Rights. (1) An appeal of an adverse[~~a negative~~] action taken

by the department regarding a service and a recipient who is not enrolled with a managed care organization [~~Medicaid beneficiary~~] shall be in accordance with 907 KAR 1:563; or[~~.~~]

(2) An appeal of an adverse action by a managed care organization regarding a service and an enrollee shall be in accordance with 907 KAR 17:010[~~An appeal of a negative action taken by the department regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~(3) An appeal of a negative action taken by the department regarding a Medicaid provider shall be in accordance with 907 KAR 1:671~~].

Section 11.[~~6.~~] Incorporation by Reference. (1) The following material is incorporated by reference:

(a) "MAP-248, Commonwealth of Kentucky, Cabinet for Health Services, Department for Medicaid Services", December 2001[~~revision~~];

(b) "Home Health Services Manual", November 1993[~~edition~~];

(c) "Technical Criteria for Reviewing Ancillary Services for Adults", February 2000 [~~Edition~~]; and

(d) "Technical Criteria for Reviewing Ancillary Services for Pediatrics", April 2000[~~Edition~~].

(2) This material may be inspected, copied or obtained, subject to applicable copyright law, at:

(a) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday 8 a.m. to 4:30 p.m.; or

(b) The Website located at http://www.chfs.ky.gov/dms/incorporated.htm. (Recodified

from 904 KAR 1:030, 5-2-86; Am. 15 Ky.R. 2458; eff. 8-5-89; 21 Ky.R. 141; eff. 8-17-94; 29 Ky.R. 1409; 1819; 2108; eff. 1-15-2003.)

907 KAR 1:030

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

907 KAR 1:030

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing by February 14, 2014 five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, Phone: (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation Number: 907 KAR 1:030
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Medicaid Program coverage provisions and requirements regarding home health services.
(b) The necessity of this administrative regulation: The administrative regulation is necessary to establish the Medicaid Program coverage provisions and requirements regarding home health services.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding home health services.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing the Medicaid Program coverage provisions and requirements regarding outpatient hospital services.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The primary amendment establishes a uniform limit of twenty (20) occupational therapy service visits, physical therapy service visits, or speech pathology service visits per recipient per calendar year. Additional services above the limit may be granted if additional services are determined to be medically necessary. This administrative regulation is being promulgated in conjunction with other administrative regulations - 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements; 907 KAR 8:020, Independent physical therapy service coverage provisions and requirements; 907 KAR 8:030, Independent speech pathology service coverage provisions and requirements; 907 KAR 10:014, Outpatient hospital services; and 907 KAR 3:005, Physician services – which will establish a uniform limit of twenty (20) therapy service visits per recipient per calendar year. Additional amendments include establishing that the Department for Medicaid Services (DMS) will not reimburse for the same service provided to the same recipient by two (2) different providers at the same time; inserting records maintenance and relate confidentiality of medical records requirements; establishing that if third party liability exists for a given recipient that the provider is to bill the third party; establishing electronic signature requirements; and establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding.

(b) The necessity of the amendment to this administrative regulation: The Department for Medicaid Services (DMS) is establishing a limit of twenty (20) therapy service visits per recipient per calendar year across various programs in order to synchronize coverage with the "benchmark" or "benchmark equivalent plan" that DMS selected for a new eligibility group known as the "Medicaid expansion" group. States which grant eligibility to the expansion group are required (by the Affordable Care Act) to establish an alternative benefit plan (array of covered services including limits) for the group. The alternative benefit plan must be based on a "benchmark" or "benchmark equivalent plan." There are four (4) acceptable such plans as established by 42 C.F.R. 440.330 and 42 U.S.C. 1396u-7(b). The four (4) are:

- The benefit plan provided by the Federal Employees Health Benefit plan Standard Blue Cross/Blue Shield Provider Option;
- The state employer health coverage that is offered and generally available to state employees;
- The health insurance plan offered through the Health Maintenance Organization (HMO) with the largest insured commercial non-Medicaid enrollment in the state; and
- Secretary-approved coverage, which is a benefit plan that the secretary has determined to provider coverage appropriate to meet the needs of the population provided that coverage.

States are required to cover every service in the given alternative benefit plan and may not pick and choose services from different alternative benefit plan options.

Kentucky selected a benchmark plan that is in the category of Health and Human Services Secretary-approved coverage. The specific plan is the Anthem Blue Cross Blue Shield Small Group Provider Preferred Option (PPO). As this plan sets a therapy service limit of twenty (20) visits per recipient per calendar year, DMS is adopting the same limit including for recipients of home health services.

The no duplication of service amendment, the amendment requiring providers to comply with Medicaid program participation requirements established in 907 KAR 1:671 and 907 KAR 1:672, and the third party liability requirement is necessary to maintain program integrity and prevent the misuse of taxpayer revenues. The electronic signature requirements are necessary to allow providers to use electronic signature and ensure that they comply with the requirements established for such in Kentucky law. Establishing that the provisions in the administrative regulation are contingent upon federal approval and federal funding is necessary to protect Kentucky taxpayer revenues from being spent if no federal funding is provided.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by comporting

with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: The amendment will assist in the effective administration of the authorizing statutes by comporting with federal requirements, enhancing the integrity of the Medicaid Program, and protecting taxpayer revenues.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Outpatient hospitals will be affected by the amendment as will Medicaid recipients who receive physical therapy services, speech pathology services, or occupational therapy services via the home health program. Currently, there are ninety-nine (99) home health agencies participating in the Medicaid Program. 379 Medicaid recipients received speech pathology services via the home health program in the most recently completed state fiscal year. 1,742 Medicaid recipients received physical therapy services via the home health program in the most recently completed state fiscal year. 883 Medicaid recipients received occupational therapy services via the home health program in the most recently completed state fiscal year.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No action is required of regulated entities or individuals.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on regulated entities or individuals.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Home health agencies will benefit by being reimbursed by the Medicaid Program for services provided in accordance with the requirements.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent $17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent $5.9 million (state and federal funds combined.) Of the $17.8 million spent by DMS on home health services, over $104,000 (state and federal funds combined) was spent on occupational therapy services; over $292,000 (state and federal funds combined) was spent on physical therapy services; and over $41,000 was spent on speech pathology services. Of the $5.9 million spent by MCOs in aggregate on home health services, over $400,000 was spent on occupational therapy services; over $678,000 was spent on physical therapy services; and over $343,000 was spent on speech pathology ser-

vices.

(b) On a continuing basis: Please see the response in (a).

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: No fee nor funding increase is necessary to implement the administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The administrative regulation neither establishes nor increases any fee.

(9) Tiering: Is tiering applied? Tiering is not applied as the requirements apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 1:030
Agency Contact: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 C.F.R. 440.220.

2. State compliance standards. KRS 205.520(3) states:

“Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. Medicaid programs are required to cover “home health services (§440.70) to any individual entitled to skilled nursing facility services.”

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:030
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? Some home health agencies may be owned by local government entities, but DMS is unable to accurately predict the impact of this amendment as revenues will depend on utilization of services. Given that more individuals will be eligible for Medicaid services (not as a result of this administrative regulation though) utilization is expected to increase; thus, an increase in revenues is a logical expectation.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? Please see the response to question (a).
   (c) How much will it cost to administer this program for the first year? DMS anticipates no additional cost as a result of the amendment. DMS cannot accurately predict the future utilization of home health services, but in the most recently completed state fiscal year DMS spent $17.8 million (state and federal funds combined) on home health services to recipients not enrolled with a managed care organization while managed care organizations (MCOs) in aggregate spent $5.9 million (state and federal funds combined.) Of the $17.8 million spent by DMS on home health services, over $104,000 (state and federal funds combined) was spent on occupational therapy services; over $292,000 (state and federal funds combined) was spent on physical therapy services; and over $41,000 was spent on speech pathology services. Of the $5.9 million spent by MCOs in aggregate on home health services, over $400,000 was spent on occupational therapy services; over $678,000 was spent on physical therapy services; and over $343,000 was spent on speech pathology services.
   (d) How much will it cost to administer this program for subsequent years? DMS anticipates no additional cost as a result of the amendment.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-): ____

Expenditures (+/-): ____

Other Explanation: